FORM STR 29-A

(See rule S.T.R. 4.43 A)

MEDICAL CHARGES REIMBURSMENT FORM

Bill No. & Date :_____ Voucher No:_____

Establishment of _____ Voucher Date:_____

1. Treasury Code :
2. D.D.O. Code :
3. Major Head:
4. Sub Major Head :
5. Minor Head :
6. Sub Head/ Scheme :
7. Plan/ Non Plan (P/L) :
8. Voted/Charged(V/C):
9. Demand No.:
10 Object Code :

(Space for Head A/C's Stamp)

Sr. No.	Name of claimant with designation	AMOUNT Gross Claim Adv. Adjusted Net Amount
1. 2. 3.		

4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	Total (Rs.) _____
15.	_____

Certificates

1. Received the contents of this bill.

2. Certified that the amount being drawn in this bill is in accordance with rules and instructions as amended from time to time.

3. Certified that cash memoes and essentiality certificate duly signed by competent authority in the case of each officer/ officials are attached.

4. Certified that no amounts drawn previously more than 3 months old is lying undisbursed and the amounts drawn 1/2/3 months previous to this date are being refunded as per details given below.

Name	Period	Amount	Drawn vide Vr.No.& Date

Appropriation

Appropriation for (year) _____ to _____ Rs. _____

Deduct Expenditure Rs. _____

(Including this bill)

Balance Available Rs. _____

Passed for Rs. _____(In words Rs.) _____

(Signature of D.D.O.)

(Signature of Controlling Officer)

(For use in Treasury Office)

Pay Rs. _____ (Rupees _____)

(Treasury Clerk) (AST) (Treasury Officer)

(For use in A.G. Office)

Admitted for Rs. _____

Objected for Rs. _____

Reasons of objection _____

(Accounts Officer)